88 Third Street
Camdenton, MO 65020
(573) 346-0660 Office
(573) 346-0688 Fax
clc@clcforkids.org
www.clcforkids.org

ENROLLMENT REQUIREMENTS

CHILD'S NAME: _____ DOB: _____

	RECEIVED (✓)	COMPLETION DATE	STAFF INITIALS
CHILD ENROLLMENT FORM (2 PAGES)			
CONSENT & PERMISSION FORM			
ENROLLMENT QUESTIONAIRE (1 PAGE)			
SERVICES QUESTIONAIRE (1 PAGE)			
CHILD MEDICAL EXAM REPORT (COMPLETED BY CHILD'S PHYSICIAN)			
COPY OF CURRENT IMMUNIZATIONS			
TUITION FORM			
CACFP INCOME ELIGIBILITY			
CACFP ENROLLMENT FORM			

This family has completed the requirements necessary for Children's Learning Center enrollment and is eligible to begin receiving services.

The first day of the 2020/2021 school year is August 24th.

Parent Signature: _____ Date: _____

Staff Signature: _____ Date: _____

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION/BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

IDENTIFYING INFORMATION

MOTHER'S/GUARDIAN'S NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF THE SAME AS ABOVE ☐	
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER
FATHER'S/GUARDIAN'S NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF THE SAME AS ABOVE ☐	
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY (OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		
NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

COMMENTS ON CHILD'S DEVELOPMENT (PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)

CACFP REQUIREMENT

RELATED CHILD

☐ Yes ☐ No — HOW IS CHILD RELATED TO CHILD CARE PROVIDER

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: ☐ Full Time ☐ Part Time		WHAT TIME DOES YOUR CHILD USUALLY ARRIVE EACH DAY?	WHAT TIME DOES YOUR CHILD USUALLY LEAVE EACH DAY?	WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION INCLUDING SHIFT CHANGES
MONDAY	☐	☐ AM ☐ PM	☐ AM ☐ PM	
TUESDAY	☐	☐ AM ☐ PM	☐ AM ☐ PM	
WEDNESDAY	☐	☐ AM ☐ PM	☐ AM ☐ PM	
THURSDAY	☐	☐ AM ☐ PM	☐ AM ☐ PM	
FRIDAY	☐	☐ AM ☐ PM	☐ AM ☐ PM	
SATURDAY	☐	☐ AM ☐ PM	☐ AM ☐ PM	
SUNDAY	☐	☐ AM ☐ PM	☐ AM ☐ PM	

CACFP REQUIREMENT

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY

☐ BREAKFAST ☐ MORNING SNACK ☐ LUNCH ☐ AFTERNOON SNACK ☐ SUPPER ☐ EVENING SNACK ☐ NONE

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY

☐ NEW YEARS'S DAY (JANUARY)	☐ MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY)	☐ PRESIDENT'S DAY (FEBRUARY)	☐ EASTER (MARCH/APRIL)
☐ MEMORIAL DAY (MAY)	☐ INDEPENDENCE DAY (JULY)	☐ LABOR DAY (SEPTEMBER)	☐ COLUMBUS DAY (OCTOBER)
☐ VETERANS DAY (NOVEMBER)	☐ ELECTION DAY (NOVEMBER)	☐ THANKSGIVING (NOVEMBER)	☐ CHRISTMAS DAY (DECEMBER)

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDICAL CARE OF MY CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.

IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE

_____

(LIST CHILDCARE FACILITY NAME HERE)

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

ACKNOWLEDGMENTS

A	I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.	PARENT/GUARDIAN INITIALS
B	I HAVE BEEN INFORMED THAT A COPY OF THE LICENSING RULES FOR CHILD CARE HOME OR THE LICENSING RULES FOR GROUP CHILD CARE HOMES AND CENTERS IS AVAILABLE AT THIS FACILITY FOR REVIEW	PARENT/GUARDIAN INITIALS
C	THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR, AND INDIVIDUAL NEEDS.	PARENT/GUARDIAN INITIALS
D	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.	PARENT/GUARDIAN INITIALS
E	I UNDERSTAND THAT, BEFORE THE FIRST DAY OF ATTENDANCE BY MY CHILD, I WILL PROVIDE PROOF OF COMPLETED AGE-APPROPRIATE IMMUNIZATIONS OR EXEMPTION FROM IMMUNIZATIONS.	PARENT/GUARDIAN INITIALS
F	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS
G	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.	PARENT/GUARDIAN INITIALS
H	I HAVE BEEN INFORMED AND HAVE RECEIVED A COPY OF THE FACILITY'S SAFE SLEEP POLICY WHEN ENROLLING A CHILD LESS THAN ONE (1) YEAR OF AGE.	PARENT/GUARDIAN INITIALS
I	I HAVE BEEN NOTIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED.	PARENT/GUARDIAN INITIALS

PARENT'S/GUARDIAN'S SIGNATURE	DATE

CACFP REQUIREMENT

FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE

USDA Nondiscrimination Statement

For all other FNS nutrition assistance programs, State or local agencies, and their subrecipients, must post the following Nondiscrimination Statement:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participation in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complain, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

88 Third Street
Camdenton, MO 65020
(573) 346-0660 Office
(573) 346-0688 Fax
clc@clcforkids.org
www.clcforkids.org

CONSENT & PERMISSION

Child's Name: _____ Date of Birth: _____

PLEASE NOTE ANY EXCEPTIONS TO THE FOLLOWING CONSENTS & PERMISSIONS

PICTURE RELEASE

Permission is given for pictures including those for identification, emergency use, educational programming and CLC publications such as brochures, fliers, newsletters, public information articles, social media and website.

- ☐ YES, I give permission for my child's picture to be taken for uses listed above.
- ☐ NO, I do not give my permission for my child's picture to be taken for the uses listed above.

CLC NEWSLETTER

Permission is given to be signed up for CLC's newsletter.

- ☐ YES, I would like to receive CLC's newsletter. Email: _____
- ☐ NO, I would not like to receive CLC's newletter.

EXCEPTIONS / RESTRICTIONS TO THE ABOVE INFORMATION:

_____

FAMILY HANDBOOK POLICY & PROCEDURES

As a parent or guardian of a child enrolled in the Children's Learning Center (CLC), I have been explained and received a Family Handbook with information that describes the program and outlines the program's policies and procedures, including Non-Discrimination and Grievance policies. I understand CLC will follow policies and procedures as outlined in the Family Handbook in regard to my child.

_____ _____ _____

Legally Responsible Person's Signature | Relationship | Date

Childrens LEARNING CENTER

NEW ENROLLMENT QUESTIONNAIRE

Date Completed: ____/____/____

Child's Name	Birth Date	Age
Parent/Guardian Name(s)		

How would you describe your child's personality and learning style?

Is your child using the toilet independently? ☐Yes ☐No
If not, to what extent does he/she need assistance?

Describe your child's peer relationships:

Please list the names and ages of any siblings your child has:

In your opinion, in what areas might we be able to give special help and encouragement to your child?

Do you have any concerns about your child? Please state any special services (i.e. speech therapy, occupational therapy, physical therapy, psychological counseling) that your child has received or is still receiving. This information is held in strict confidence and is intended to assist the staff in working with your child. Does your child have any allergies, medication, or other health info that you would like to share?

Please list three activities your child enjoys:

What expectations/goals do you have for your child in sending him/her to Children's Learning Center?

Please use this space if there is any additional information about your child that you would like to share:

Please indicate your preferred method of daily communication by Children's Learning Center and your child's teacher:

☐Text ☐Email ☐Facebook ☐Note In Cubby

Email Address:
Phone Number For Contact:

Even if you prefer to receive your daily communication in a form other than texting, is it ok to text special communications? ☐Yes ☐No

Is it ok to send pictures via text that are specific to your child? ☐Yes ☐No

Child Name:

DOB:

In what county do you reside?

Does your child receive services from therapists?
Yes ☐ No ☐
If yes, please list your provider:

Physical Therapist:

Occupational Therapist:

Speech Therapist:

Special Instructor:

Other:

Is your child enrolled in the Missouri First Steps Program?
Yes ☐ No ☐
Are you or your child a client of CCDDR? If yes, what is the name of your support coordinator?
Yes ☐ No ☐

Is your child on an IEP?
Yes ☐ No ☐

Does your child have any special sensory needs? For example, are there any smells, sights, or other senses that are sensitive or need extra attention?

Additional information you would like to provide:

Does your child require help with eating? What kind of cup does your child drink out of?

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)

SAVE
PRINT
RESET

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

CURRENT STATE OF HEALTH

Based on my assessment of this child's medical history, current state of health and my physical examination of the child on ____ / ____ / ____, this child can participate in a child care program. This child has no special care needs unless specified below.

(Date of medical examination must be within the last 12 months.)

PHYSICIAN'S INSTRUCTIONS FOR SPECIALIZED CARE

Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE

PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

NAME AND ADDRESS OF CLINIC, GROUP, PRACTICE OR OTHER (MAY USE STAMP.)	IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN'S NAME (PLEASE PRINT.)
	TELEPHONE NUMBER

Missouri Department of Health and Senior Services

ERROR: invalidfont Child Care Regulation
OFFENDING COMMAND: show

INDIVIDUAL PLAN FOR SPECIALIZED CARE

STACK:

( )

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

AREA OF CONCERN

ADAPTIVE EQUIPMENT OR SUPPLIES NEEDED AT DAY CARE

MEDICATION/TREATMENT CHILD IS TO RECEIVE AT FACILITY DURING CHILD CARE HOURS

If the child is to receive treatments during his/her scheduled hours of care, how and by whom is this treatment to be administered?

SYMPTOMS/INDICATORS/POSSIBLE PROBLEMS RELATING TO CHILD'S CONDITION/TREATMENT HEALTH PROBLEMS THAN CAN RESULT IN AN EMERGENCY

PHYSICIAN/SPECIALIST SIGNATURE

CHILD'S NAME: _____

DATE OF BIRTH: _____

CLC TUITION

STEP 1:

HALF DAY OPTIONS

HALF DAY PREK w/ BREAKFAST

TWO HALF DAYS PER WEEK

- $120 MONTHLY T/R (AM) 7:30AM-11:30AM
- $145 MONTHLY T/R (PM) 11:30AM-4:30PM

THREE HALF DAYS PER WEEK

- $180 MONTHLY M/W/F (AM) 7:30AM-11:30AM
- $205 MONTHLY M/W/F (PM) 11:30AM-4:30PM

FOUR HALF DAYS PER WEEK

- $240 MONTHLY M-F (AM) 7:30AM-11:30AM
- $265 MONTHLY M-F (PM) 11:30AM-4:30PM

FIVE HALF DAYS PER WEEK

- $300 MONTHLY M-F (AM) 78:30AM-11:30AM
- $325 MONTHLY M/W/F (PM) 11:30AM-4:30PM

FULL DAY OPTIONS

FULL DAY PREK w/ BREAKFAST, LUNCH, & 1 SNACK

ONE FULL DAY PER WEEK

- $120 MONTHLY 7:30AM-4:30PM

TWO FULL DAYS PER WEEK

- $240 MONTHLY T/R 7:30AM-4:30PM

THREE FULL DAYS PER WEEK

- $360 MONTHLY M/W/F 7:30AM-4:30PM

FOUR FULL DAYS PER WEEK

- $480 MONTHLY 4 DAYS 7:30AM-4:30PM

FIVE FULL DAYS PER WEEK

- $600 MONTHLY M-F 7:30AM-4:30PM

STEP 2: **YEARLY FEE**

- **$75 Registration Yearly Fee**

Administration Notes:

OTHER

ADDITIONAL NEEDS/NOTES:

_____

_____

Parent/Guardian Signature:_____ Date:_____

Administrator Signature:_____ Date:_____

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the child care center.

PART 1: CHILDREN ENROLLED AT THE CHILD CARE CENTER

Complete information below for children enrolled at the center. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number **for all of the children listed in Part 1.**

NAME (first and last)	FOSTER CHILD	BIRTH DATE	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER
		/ /		
		/ /		
		/ /		
		/ /		

PART 2: HOUSEHOLD AND INCOME INFORMATION

List all members of the household not including the children listed in Part 1. Indicate source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months. Foster children may be eligible regardless of household income. Contact the center for more information.

INCOME BASED ON (CHECK ONE) ☐ YEARLY ☐ MONTHLY ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

PART 3: RACIAL ETHNIC INFORMATION (You are not required to answer this section)

Are you of Hispanic or Latino origin? ☐ YES ☐ NO

What is your race? (Select one or more)

AMERICAN INDIAN OR ALASKA NATIVE	ASIAN	BLACK OR AFRICAN AMERICAN	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	WHITE
☐	☐	☐	☐	☐

PART 4: SIGNATURE

I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT FAMILY MEMBER	SOCIAL SECURITY NUMBER (LAST 4 DIGITS ONLY)	DATE
	XXX-XX-	/ /
PRINTED NAME OF ADULT	ADDRESS	PHONE NUMBER
		( ) -

Section 9 of the National School Lunch Act requires that, unless your children's SNAP or Temporary Assistance case number is provided, you must include the last four digits of a social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of the last four digits of a social security number is not mandatory, but if the last four digits of a social security number are not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

FOR CENTER USE ONLY

TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE): YEAR ☐	MONTH ☐	2 X A MONTH ☐	EVERY 2 WEEKS ☐	WEEKLY ☐	SNAP (Food Stamp) ☐	TEMPORARY ASSISTANCE ☐

Eligibility Determination: ☐ Free ☐ Reduced ☐ Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE

MO 580-1314 (2-11) CACFP-205

This institution is an equal opportunity provider.

MISSOURI DEPARTMENTOF HEALTH AND SENIOR SERVICES (MDHSS)
COMMUNITY FOOD AND NUTRITION ASSISTANCE – CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

CACFP ENROLLMENT FORM FOR CHILD CARE CENTERS

NOTE: DEPARTMENT OF HEALTH AND SENIOR SERVICES OFFICIALS OR A SPONSORING ORGANIZATION REPRESENTATIVE MAY CONTACT YOU TO VERIFY INFORMATION.

CHILD'S FULL NAME	DATE OF BIRTH

PARENT OR GUARDIAN NAME	STREET ADDRESS

CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
			( )

NAME OF CHILD CARE CENTER	PHONE NUMBER
	( )

CENTER CONTACT PERSON'S NAME	CHILD'S DATE OF ENROLLMENT (FIRST DATE ATTENDING THIS CENTER)

IN THIS COLUMN, CHECK THE DAYS YOUR CHILD USUALLY ATTENDS DAY CARE ⇊		WHAT TIME DOES YOUR CHILD USUALLY ARRIVE EACH DAY? CIRCLE AM OR PM	WHAT TIME DOES YOUR CHILD USUALLY LEAVE EACH DAY? CIRCLE AM OR PM	WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION.
MON		AM PM	AM PM	
TUES		AM PM	AM PM	
WED		AM PM	AM PM	
THURS		AM PM	AM PM	
FRI		AM PM	AM PM	
SAT		AM PM	AM PM	
SUN		AM PM	AM PM	

CHECK WHEN YOUR CHILD IS IN CARE AT THIS CENTER

- ☐ FULL DAY CARE
- ☐ HALF DAY – MORNING
- ☐ HALF DAY – AFTERNOON
- ☐ BEFORE SCHOOL CARE
- ☐ AFTER SCHOOL CARE
- ☐ BEFORE AND AFTER SCHOOL CARE
- ☐ EVENING CARE
- ☐ OVERNIGHT CARE

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS CENTER

- ☐ BREAKFAST
- ☐ MORNING SNACK
- ☐ LUNCH
- ☐ AFTERNOON SNACK
- ☐ SUPPER
- ☐ EVENING SNACK

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS CENTER

- ☐ NEW YEARS DAY (JANUARY 1)
- ☐ MARTIN LUTHER KING'S BIRTHDAY (JANUARY)
- ☐ PRESIDENT'S DAY (FEBRUARY)
- ☐ MEMORIAL DAY (MAY)
- ☐ INDEPENDENCE DAY (JULY 4)
- ☐ LABOR DAY (SEPTEMBER)
- ☐ THANKSGIVING DAY (NOVEMBER)
- ☐ CHRISTMAS DAY (DECEMBER 25)

SIGNATURE OF PARENT OR GUARDIAN	DATE

ANNUAL UPDATES: THE PARENT OR GUARDIAN SIGNING THIS FORM CERTIFIES THAT THE ENROLLMENT INFORMATION IS CORRECT. IF INFORMATION HAS CHANGED, THE PARENT OR GUARDIAN HAS WRITTEN THE APPROPRIATE CHANGES ON THE FORM AND INITIALED THE CHANGE. IF THERE ARE MANY CHANGES, PLEASE COMPLETE A NEW FORM.

	PARENT SIGNATURE	DATE
FIRST ANNUAL UPDATE		
SECOND ANNUAL UPDATE		
THIRD ANNUAL UPDATE		

CLC
2021-22
School Supply List

Classroom Supplies

- 2 packages of thermal laminating pouches (8.5x11)
- 2 containers of play-doh and/or 2 containers of bubbles
- Skinny markers/pipsqueaks washable markers
- Jumbo crayons and/or expo markers
- 1 box baggies - any size
- 2 packs of unscented baby wipes
- 1 box of tissues
- 8-12 rolls of paper towels
- 1 package of toilet paper
- 1 Tub/Container for toys on shelves

Throughout the year, we may ask for help to replenish these items.

Personal Supplies

- Sunscreen (if needed)
- Additional Baby wipes
- Diaper ointment (if needed)
- Diapers or pull-ups (if needed)
- 2 sets of extra clothes (pants/shorts, shirts, socks, underwear – weather appropriate)
- Blanket (If needed for nap time, cot sheets are supplied by CLC)
- Water bottle – dishwasher safe